Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number:
M4-12-1205-01

MDFR Received Date
DECEMBER 15, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: 1,777.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant is the requestor in this dispute. Rule 133.307(b)(3) does indicate an injured employee may request medical fee dispute resolution for reimbursement of medical expenses paid by the employee. However, there is no clarifying information in the requestor's dispute packet other than a 'Patient Drug History' from Express Drugs. Review of Texas Mutual's claim file shows the requestor did submit billing to Texas Mutual for reimbursement of medication. Dates 2/23/11 through 5/17/11 were paid. However, the remaining dates were denied as unrelated to the compensable injury.

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy. 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2011 through November 7, 2011	Out-of-Pocket Expenses – Prescription medications – Denied as unrelated to the extent of injury	$858.46	$0.00
February 23, 2011, through May 17, 2011	Out-of-Pocket Expenses – Prescription medications	$919.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
3. 28 Texas Administrative Code §134.504 sets out the guidelines for pharmaceutical expenses incurred by the injured employee.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 13, 2012

- W1 – Workers Compensation State Fee Schedule adjustment.
- 517 – Paid at est. U&C based on research, Labor Code Sec 413.043 and PFG. 28 Tex Admin Code 134.503 to electronic bill.
- 219 – Based on Extent of Injury
- 246 – The treatment/service has been determined to be unrelated to the Extent of Injury, final adjudication has not taken place.

Findings

1. Pursuant to 28 Texas Administrative Code §133.307(c)(1)(B)(i) a requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request may be filed later than one year after the dates(s) of service if a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability.

   Dates of service June 22, 2011 through November 7, 2011 were denied by the insurance carrier using denial reasons 219 – "Based on Extent of Injury" and 246 – "The treatment/service has been determined to be unrelated to the Extent of Injury, final adjudication has not taken place. The injured worker may resubmit these denied dates of service after the extent of injury issue has been resolved. The injured worker should resubmit these dates of service using the format set out in 28 Texas Administrative Code §133.307 and include a copy of the final decision of the Hearing Officer.

2. Pursuant to 28 Texas Administrative Code §134.504(a)(2) the insurance carrier shall make appropriate payment to the injured employee in accordance with §134.503, or notify the injured employee of a reduction or denial of the payment within 45 days of receipt of the request for reimbursement from the injured employee. If the insurance carrier does not reimburse the full amount requested, or denies payment the carrier shall include a full and complete explanation of

the reasons. The insurance carrier reimbursed the injured worker in accordance with 28 Texas Administrative Code §134.503(a)(2)(A). Therefore, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 18, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.